Complete Summary

GUIDELINE TITLE

Heavy menstrual bleeding.

BIBLIOGRAPHIC SOURCE(S)

National Collaborating Centre for Women's and Children's Health. Heavy menstrual bleeding. London (UK): Royal College of Obstetricians and Gynaecologists (RCOG); 2007 Jan. 164 p. [606 references]

GUIDELINE STATUS

This is the current release of the guideline.

Clinical guidelines commissioned by National Institute for Health and Clinical Excellence (NICE) are published with a review date 4 years from date of publication. Reviewing may begin earlier than 4 years if significant evidence that affects guideline recommendations is identified sooner. The updated guideline will be available within 2 years of the start of the review process.

COMPLETE SUMMARY CONTENT

SCOPE

DISEASE/CONDITION(S)

Heavy menstrual bleeding

GUIDELINE CATEGORY

Counseling
Diagnosis

Evaluation
Management
Treatment

CLINICAL SPECIALTY

Family Practice
Internal Medicine
Obstetrics and Gynecology
Radiology
Surgery

INTENDED USERS

Advanced Practice Nurses
Health Care Providers
Health Plans
Managed Care Organizations
Nurses
Patients
Physicians
Public Health Departments

GUIDELINE OBJECTIVE(S)

To provide advice on:

- Patient educational interventions and information provision to improve patient satisfaction
- Diagnosis of women presenting with heavy menstrual bleeding (HMB), including guidance on appropriate investigations and referral, and the cost-effectiveness of undertaking such investigations
- Medical management of HMB, including short- and long-term outcomes, adverse events, cost-effectiveness and subsequent treatment
- Indications for referral to secondary care management
- Determining whether, and when, surgical procedures are most appropriate
- Operative procedures used for endometrial ablation/resection in HMB, including short- and long-term outcomes, cost-effectiveness, adverse events and subsequent treatment
- Uterine artery embolisation (UAE) in HMB, including short- and long-term outcomes, cost-effectiveness, adverse events and subsequent treatment
- Operative procedures and other techniques used for hysterectomy and myomectomy in HMB, including short- and long-term outcomes, adverse events and subsequent treatment, as well as guidance on minimal access techniques (hysteroscopy or laparoscopy)
- Issues relating to the removal of healthy ovaries, when hysterectomy is the most appropriate option
- The competencies required by practitioners who wish to carry out surgical techniques and other interventions such as UAE

TARGET POPULATION

Women between the ages of puberty and menopause who have heavy menstrual bleeding (HMB)

This guideline does not address:

- Women with conditions where HMB is not the main presenting menstrual symptom – an example is endometriosis, which is often dysmenorrhoea associated with pelvic pain; such conditions will not be covered even if there is concurrent menorrhagia
- Issues relating to anaesthetics in surgery
- Issues relating to fertility will only be examined as they relate to treatment for HMB but not as a separate issue
- Women with HMB who are receiving exogenous steroids, such as hormone replacement therapy (HRT)
- Gynecological bleeding problems (other than HMB)

INTERVENTIONS AND PRACTICES CONSIDERED

1. Diagnostic evaluations
    - History taking
    - Physical examination
    - Laboratory tests, including full blood count, coagulation test
    - Structural/histological tests, including biopsy, ultrasound, hysteroscopy
2. Patient education and choice
    - Patient-oriented guidelines and information on potential unwanted outcomes
    - Optional second opinion
    - Genetic counseling for women with a family history of breast of ovarian cancer
3. Pharmaceutical interventions
    - Intrauterine levonorgestrel-releasing systems
    - Combined oral contraceptives (COCs)
    - Oral progestogens
    - Injected/depot progestogens
    - Hormone replacement therapy (HRT)
    - Gonadotrophin-releasing hormone analogue
    - Tranexamic acid
    - Nonsteroidal anti-inflammatory drugs (NSAIDs)
    - Etamsylate (not recommended)
4. Surgery/radiosurgery
    - Endometrial ablation
    - Dilatation and curettage (not recommended)
    - Uterine artery embolisation (UAE) for fibroid tumors
    - Myomectomy
    - Hysterectomy (vaginal, abdominal, laparoscopic) (not recommended for first-line treatment)
    - Oophorectomy/bilateral oophorectomy (not recommended in women with healthy ovaries)
5. Training, maintenance of skills, and governance of physicians treating heavy menstrual bleeding

MAJOR OUTCOMES CONSIDERED

- Change in menstrual blood loss (MBL)
- Complications or adverse events associated with treatments
- Change in health-related quality of life (HRQoL) measures
- Cost-effectiveness of treatment

METHODOLOGY

METHODS USED TO COLLECT/SELECT EVIDENCE

Hand-searches of Published Literature (Primary Sources)
Hand-searches of Published Literature (Secondary Sources)
Searches of Electronic Databases

DESCRIPTION OF METHODS USED TO COLLECT/SELECT THE EVIDENCE

Literature Search Strategy

Initial scoping searches were executed to identify relevant guidelines (local, national and international) produced by other development groups. The reference lists in these guidelines were checked against subsequent searches to identify missing evidence.

Relevant published evidence to inform the guideline development process and answer the clinical questions was identified by systematic search strategies. Additionally, stakeholder organizations were invited to submit evidence for consideration by the Guideline Development Group (GDG) provided it was relevant to the clinical questions, and of equivalent or better quality than evidence identified by the search strategies.

Systematic searches to answer the clinical questions formulated and agreed by the GDG were executed using the following databases via the OVID platform: Medline (1966 onwards), Embase (1980 onwards), Cumulative Index to Nursing and Allied Health Literature (1982 onwards), British Nursing Index (1985 onwards), PsycINFO (1967 onwards), Cochrane Central Register of Controlled Trials (2nd Quarter 2006), Cochrane Database of Systematic Review (1st Quarter 2006) and Database of Abstracts of Reviews of Effects (1st Quarter 2006).

Search strategies combined relevant controlled vocabulary and natural language in an effort to balance sensitivity and specificity. Unless advised by the GDG, searches were not date specific. Language restrictions were not applied to searches. Both generic and specially developed methodological search filters were used appropriately.

Searches to identify economic studies were undertaken using the above databases and the National Health Service (NHS) Economic Evaluations Database (NHS EED) produced by the Centre for Reviews and Dissemination at the University of York.

There was no systematic attempt to search grey literature (conferences, abstracts, theses and unpublished trials). Hand searching of journals not indexed on the databases was not undertaken.

At the end of the guideline development process, searches were updated and re-executed, thereby including evidence published and included in the databases up to June 2006. Any evidence published after this date was not included. This date should be considered the starting point for searching for new evidence for future updates to this guideline.

Further details of the search strategies, including the methodological filters employed, can be obtained from the National Collaborating Centre for Women's and Children's Health (NCC-WCH).

NUMBER OF SOURCE DOCUMENTS

Not stated

METHODS USED TO ASSESS THE QUALITY AND STRENGTH OF THE EVIDENCE

Weighting According to a Rating Scheme (Scheme Given)

RATING SCHEME FOR THE STRENGTH OF THE EVIDENCE

Levels of Evidence for Intervention Studies

Level	Source of Evidence
1++	High-quality meta-analyses, systematic reviews of randomised controlled trials (RCTs) or RCTs with a very low risk of bias
1+	Well-conducted meta-analyses, systematic reviews of RCTs or RCTs with a low risk of bias
1−	Meta-analyses, systematic reviews of RCTs or RCTs with a high risk of bias
2++	High-quality systematic reviews of case–control or cohort studies; high-quality case–control or cohort studies with a very low risk of confounding bias or chance and a high probability that the relationship is causal
2+	Well-conducted case–control or cohort studies with a low risk of confounding bias or chance and a moderate probability that the relationship is causal
2−	Case–control or cohort studies with a high risk of confounding bias or chance and a significant risk that the relationship is not causal
3	Non-analytical studies (for example, case reports, case series)
4	Expert opinion, formal consensus

Levels of Evidence for Studies of the Accuracy of Diagnostics Tests

Level	Type of Evidence

Level	Type of Evidence
Ia	Systematic reviews (with homogeneity)[a] of level-1 studies[b]
Ib	Level-1 studies[b]
II	Level-2 studies[c]; systematic reviews of level-2 studies
III	Level-3 studies[d]; systematic reviews of level-3 studies
IV	Consensus, expert committee reports or opinions and/or clinical experience without explicit critical appraisal; or based on physiology, bench research or 'first principles'

[a] Homogeneity means there are no or only minor variations in the directions and degrees of results between individual studies that are included in the systematic review.

[b] Level-1 studies are studies that use a blind comparison of the test with a validated reference standard (gold standard) in a sample of patients that reflects the population to whom the test would apply.

[c] Level-2 studies are studies that have only one of the following:

- Narrow population (the sample does not reflect the population to whom the test would apply)
- Use a poor reference standard (defined as that where the 'test' is included in the 'reference', or where the 'testing' affects the 'reference')
- The comparison between the test and reference standard is not blind
- Case–control studies

[d] Level-3 studies are studies that have at least two or three of the features listed above.

METHODS USED TO ANALYZE THE EVIDENCE

Decision Analysis
Meta-Analysis
Review of Published Meta-Analyses
Systematic Review with Evidence Tables

DESCRIPTION OF THE METHODS USED TO ANALYZE THE EVIDENCE

Synthesis of Clinical Effectiveness Evidence

Evidence relating to clinical effectiveness was reviewed using established guides and classified using the established hierarchical system shown in "Levels of evidence for intervention studies" (See the "Rating Scheme for the Strength of the Evidence" field in this summary). This system reflects the susceptibility to bias that is inherent in particular study designs.

The type of clinical question dictates the highest level of evidence that may be sought. In assessing the quality of the evidence, each study receives a quality rating coded as '++', '+' or '−'. For issues of therapy or treatment, the highest possible evidence level (EL) is a well-conducted systematic review or meta-

analysis of randomised controlled trials (RCTs; EL=1++) or an individual RCT (EL=1+). Studies of poor quality are rated as '−'. Usually, studies rated as '−' should not be used as a basis for making a recommendation, but they can be used to inform recommendations. For issues of prognosis, the highest possible level of evidence is a cohort study (EL=2−).

For each clinical question, the highest available level of evidence was selected. Where appropriate, for example if a systematic review, meta-analysis or RCT existed in relation to a question, studies of a weaker design were not included. Where systematic reviews, meta-analyses and RCTs did not exist, other appropriate experimental or observational studies were sought. For diagnostic tests, test evaluation studies examining the performance of the test were used if the efficacy of the test was required, but where an evaluation of the effectiveness of the test in the clinical management of patients and the outcome of disease was required, evidence from RCTs or cohort studies was used.

The system described above covers studies of treatment effectiveness. However, it is less appropriate for studies reporting diagnostic tests of accuracy. In the absence of a validated ranking system for this type of test, the National Institute for Health and Clinical Excellence (NICE) has developed a hierarchy for evidence of accuracy of diagnostic tests that takes into account the various factors likely to affect the validity of these studies.

For economic evaluations, no standard system of grading the quality of evidence exists. Economic evaluations that are included in the review have been assessed using a quality assessment checklist based on good practice in decision-analytic modelling.

Evidence was synthesised qualitatively by summarising the content of identified papers in evidence tables and agreeing brief statements that accurately reflected the evidence. Quantitative synthesis (meta-analysis) was performed where appropriate.

Summary results and data are presented in the guideline text. More detailed results and data are presented in the evidence tables on the CD-ROM accompanying the original guideline document. Where possible, dichotomous outcomes are presented as relative risks (RRs) with 95% confidence intervals (CIs), and continuous outcomes are presented as mean differences with 95% CIs or standard deviations (SDs). Meta-analyses based on dichotomous outcomes are presented as pooled odds ratios (ORs) with 95% CIs, and meta-analyses based on continuous outcomes are presented as weighted mean differences (WMDs) with 95% CIs.

METHODS USED TO FORMULATE THE RECOMMENDATIONS

Expert Consensus (Delphi)
Expert Consensus (Nominal Group Technique)
Informal Consensus

DESCRIPTION OF METHODS USED TO FORMULATE THE RECOMMENDATIONS

The guideline was developed by a multi-professional and lay working group (the Guideline Development Group or GDG) convened by the National Collaborating Centre for Women's and Children's Health (NCC-WCH). The membership included:

- Two consumer/patient representatives
- Two general practitioners
- One interventional radiologist
- One epidemiologist
- One nurse-specialist
- Four gynaecologist surgeons

Staff from the NCC-WCH provided methodological support for the guideline development process, undertook systematic searches, retrieval and appraisal of the evidence, health economics modelling and wrote successive drafts of the guideline.

Forming and Grading Recommendations

For each clinical question, recommendations were derived using, and explicitly linked to, the evidence that supported them. In the first instance, informal consensus methods were used by the Guideline Development Group (GDG) to agree evidence statements and recommendations. Shortly before the consultation period, formal consensus methods were used to agree guideline recommendations (modified Delphi technique) and to select five to ten key priorities for implementation (nominal group technique).

Each recommendation was graded according to the level of evidence upon which it was based using the established system. For issues of therapy or treatment, the best possible level of evidence (a systematic review or meta-analysis or an individual RCT) equates to a grade A recommendation. For issues of prognosis, the best possible level of evidence (a cohort study) equates to a grade B recommendation. However, this should not be interpreted as an inferior grade of recommendation because it represents the highest level of relevant evidence.

In addition, the GDG made research recommendations for areas where it was believed that research was needed.

RATING SCHEME FOR THE STRENGTH OF THE RECOMMENDATIONS

Classification of Recommendations

Class	Evidence
A	• At least one meta-analysis, systematic review, or randomised controlled trial (RCT) that is rated as 1++, and is directly applicable to the target population, or • A systematic review of RCTs or a body of evidence that consists principally of studies rated as 1+, is directly applicable to the target population and demonstrates overall consistency of results, or • Evidence drawn from a National Institute for Health and Clinical

Class	Evidence
	Excellence (NICE) technology appraisal.
B	• A body of evidence that includes studies rated as 2++, is directly applicable to the target population and demonstrates overall consistency of results, or • Extrapolated evidence from studies rated as 1++ or 1+.
C	• A body of evidence that includes studies rated as 2+, is directly applicable to the target population and demonstrates overall consistency of results, or • Extrapolated evidence from studies rated as 2++.
D	• Evidence level 3 or 4, or • Extrapolated evidence from studies rated as 2+, or • Formal consensus
D(GPP)	• A good practice point (GPP) is a recommendation for best practice based on the experience of the Guideline Development Group.

COST ANALYSIS

The aim of the economic input into the guideline was to inform the Guideline Development Group (GDG) of potential economic issues relating to heavy menstrual bleeding (HMB). The health economist helped the GDG by identifying topics within the guideline that might benefit from economic analysis, reviewing the available economic evidence and, where necessary, conducting (or commissioning) economic analysis. Reviews of published health economic evidence are presented alongside the reviews of clinical evidence and are incorporated within the relevant evidence statement and recommendations. For some questions, no published evidence was identified, and decision-analytic modelling was undertaken. Results of this modelling are presented in Appendix A of the original guideline.

Economic evaluations in this guideline have been conducted in the form of a cost-effectiveness analysis, with the health effects measured in an appropriate non-monetary outcome indicator. The NICE technology appraisal programme measures outcomes in terms of quality-adjusted life years (QALYs). Where possible, this approach has been used in the development of this guideline. However, where it has not been possible to estimate QALYs gained as a result of an intervention, an alternative measure of effectiveness has been used.

Cost-effectiveness analysis, with the units of effectiveness expressed in QALYs (known as cost–utility analysis), is widely recognised as a useful approach for measuring and comparing the efficiency of different health interventions. The

QALY is a measure of a health outcome which assigns to each period of time (generally 1 year) a weight, ranging from 0 to 1, corresponding to health-related quality of life during that period. It is one of the most commonly used outcome measures in health economics. A score of 1 corresponds to full health and a score of 0 corresponds to a health state equivalent to death. Negative valuations, implying a health state worse than death, are possible. Health outcomes using this method are measured by the number of years of life in a given health state, multiplied by the value of being in that health state.

In addition, two companion documents related to cost of implementing the guidelines are available: "Heavy menstrual bleeding: Costing template" and "Heavy menstrual bleeding: Costing report" (See "Availability of Companion Documents" field in this summary).

METHOD OF GUIDELINE VALIDATION

External Peer Review
Internal Peer Review

DESCRIPTION OF METHOD OF GUIDELINE VALIDATION

The guideline was validated through two consultations.

1. The first draft of the guideline (The full guideline, National Institute for Clinical Excellence [NICE] guideline and Quick Reference Guide) was consulted with Stakeholders and comments were considered by the Guideline Development Group (GDG).
2. The final consultation draft of the full guideline, the NICE guideline and the Information for the Public were submitted to stakeholders for final comments.

The final draft was submitted to the Guideline Review Panel for review prior to publication.

RECOMMENDATIONS

MAJOR RECOMMENDATIONS

Levels of evidence for the accuracy of diagnostic tests (Ia-IV) and for interventions (1++ to 4), and grading of recommendations (A-D), are defined at the end of the "Major Recommendations" field.

In addition to the evidence-based recommendations, the Guideline Development Group (GDG) also identifies best practice based on the experience of the group (D[GPP]).

Impact of Heavy Menstrual Bleeding (HMB) on Women

C - HMB should be recognised as having a major impact on a woman's quality of life, and any intervention should aim to improve this rather than focusing on menstrual blood loss.

D - For clinical purposes, HMB should be defined as excessive menstrual blood loss which interferes with the woman's physical, emotional, social, and material quality of life, and which can occur alone or in combination with other symptoms. Any interventions should aim to improve quality of life measures.

History Taking, Examination and Investigations for HMB

History Taking for HMB

D(GPP) - Initially, a history should be taken from the woman. This should cover the nature of the bleeding, related symptoms that might suggest structural or histological abnormality, impact on quality of life and other factors that may determine treatment options (such as presence of comorbidity).

D(GPP) - Clinicians should take into account the range and natural variability in menstrual cycles and blood loss when diagnosing HMB, and should discuss this variation with the woman. If the woman feels that she does not fall within the normal ranges, care options should be discussed.

D(GPP) - If the history suggests HMB without structural or histological abnormality, pharmaceutical treatment can be started without carrying out a physical examination or other investigations at initial consultation in primary care, unless the treatment chosen is levonorgestrel-releasing intrauterine system (LNG-IUS).

D(GPP) - If the history suggests HMB with structural or histological abnormality, with symptoms such as intermenstrual or post-coital bleeding, pelvic pain and/or pressure symptoms, a physical examination and/or other investigations (such as ultrasound) should be performed.

Measurement of Menstrual Blood Loss

D(GPP) - Measuring menstrual blood loss either directly (alkaline haematin) or indirectly ('pictorial blood loss assessment chart') is not routinely recommended for HMB. Whether menstrual blood loss is a problem should be determined not by measuring blood loss but by the woman herself.

Physical Examination for HMB

D(GPP) - A physical examination should be carried out before all:

- LNG-IUS fittings*
- Investigations for structural abnormalities
- Investigations for histological abnormalities

* See "Long-acting reversible contraception, NICE clinical guideline 30, http://guidance.nice.org.uk/CG30, for more detail. (National Guideline Clearinghouse summary of the NICE guideline Long-acting reversible contraception: the effective and appropriate use of long-acting reversible contraception.)

D(GPP) - Women with fibroids that are palpable abdominally or who have intra-cavity fibroids and/or whose uterine length as measured at ultrasound or

hysteroscopy is greater than 12 cm should be offered immediate referral to a specialist.

Laboratory Tests for HMB

C - A full blood count test should be carried out on all women with HMB. This should be done in parallel with any HMB treatment offered.

C - Testing for coagulation disorders (for example, von Willebrand disease) should be considered in women who have had HMB since menarche and have personal or family history suggesting a coagulation disorder.

B - A serum ferritin test should not routinely be carried out on women with HMB.

C - Female hormone testing should not be carried out on women with HMB.

C - Thyroid testing should only be carried out when other signs and symptoms of thyroid disease are present.

Investigations for HMB

D(GPP) - If appropriate, a biopsy should be taken to exclude endometrial cancer or atypical hyperplasia. Indications for a biopsy include, for example, persistent intermenstrual bleeding, and in women aged 45 and over treatment failure or ineffective treatment.

D(GPP) - Imaging should be undertaken in the following circumstances:

- The uterus is palpable abdominally
- Vaginal examination reveals a pelvic mass of uncertain origin
- Pharmaceutical treatment fails

A - Ultrasound is the first-line diagnostic tool for identifying structural abnormalities.

A - Hysteroscopy should be used as a diagnostic tool only when ultrasound results are inconclusive, for example, to determine the exact location of a fibroid or the exact nature of the abnormality.

D(GPP) - If imaging shows the presence of uterine fibroids then appropriate treatment should be planned based on size, number and location of the fibroids.

A - Saline infusion sonography should not be used as a first-line diagnostic tool.

B - Magnetic resonance imaging (MRI) should not be used as a first-line diagnostic tool.

B - Dilatation and curettage alone should not be used as a diagnostic tool.

D(GPP) - Where dilatation is required for non-hysteroscopic ablative procedures, hysteroscopy should be used immediately prior to the procedure to ensure correct placement of the device.

Education and Information Provision

Education for Women with HMB

A - A woman with HMB referred to specialist care should be given information before her outpatient appointment. The Institute's information for patients ("Understanding NICE guidance") is available from http://www.nice.org.uk/CG044publicinfo. (See also "Patient Resources" field in this summary.)

D(GPP) - Although respect for autonomy, and individual choice, are important for the NHS and its users, they should not have the consequence of promoting the use of interventions that are not clinically and/or cost-effective.

D(GPP) - Women should be made aware of the impact on fertility that any planned surgery or uterine artery embolisation (UAE) may have, and if a potential treatment (hysterectomy or ablation) involves the loss of fertility then opportunities for discussion should be made available.

Women should be given the following information on potential unwanted outcomes.

Table: Potential Unwanted Outcomes of Interventions for HMB

Intervention	**Potential unwanted outcomes experienced by some women** (common = 1 in 100 chance, less common = 1 in 1000 chance, rare = 1 in 10,000 chance, very rare = 1 in 100,000 chance)	
Levonorgestrel-releasing intrauterine system (LNG-IUS)	Common:	irregular bleeding that may last for over 6 months; hormone-related problems such as breast tenderness, acne or headaches, which, if present, are generally minor and transient
	Less common:	amenorrhoea
	Rare:	uterine perforation at the time of IUS insertion
Tranexamic acid	Less common:	indigestion; diarrhoea; headaches
Nonsteroidal anti-inflammatory drugs (NSAIDs)	Common:	indigestion; diarrhoea
	Rare:	worsening of asthma in sensitive individuals; peptic ulcers with possible bleeding and

Intervention	Potential unwanted outcomes experienced by some women (common = 1 in 100 chance, less common = 1 in 1000 chance, rare = 1 in 10,000 chance, very rare = 1 in 100,000 chance)	
		peritonitis
Combined oral contraceptives (COCs)	Common:	mood changes; headaches; nausea; fluid retention; breast tenderness
	Rare:	deep vein thrombosis; stroke; heart attacks
Oral progestogen (norethisterone)	Common:	weight gain; bloating; breast tenderness; headaches; acne (but all are usually minor and transient)
	Rare:	depression
Injected progestogen	Common:	weight gain; irregular bleeding; amenorrhoea; premenstrual-like syndrome (including bloating, fluid retention, breast tenderness)
	Less common:	small loss of bone mineral density, largely recovered when treatment is discontinued
Gonadotrophin-releasing hormone analogue (GnRH-a)	Common:	menopausal-like symptoms (such as hot flushes, increased sweating, vaginal dryness)
	Less common:	osteoporosis, particularly trabecular bone with longer than 6 months' use
Endometrial ablation	Common:	vaginal discharge; increased period pain or cramping (even if no further bleeding); need for additional surgery
	Less common:	infection
	Rare:	perforation (but very rare with second-generation techniques)
Uterine artery embolisation (UAE)	Common:	persistent vaginal discharge; post-embolisation syndrome – pain, nausea, vomiting and fever (not involving hospitalisation)
	Less common:	need for additional surgery; premature ovarian failure, particularly in women over 45 years old; haematoma
	Rare:	haemorrhage; non-target embolisation causing tissue necrosis; infection causing septicaemia

Intervention	Potential unwanted outcomes experienced by some women (common = 1 in 100 chance, less common = 1 in 1000 chance, rare = 1 in 10,000 chance, very rare = 1 in 100,000 chance)	
Myomectomy	Less common:	adhesions (which may lead to pain and/or impaired fertility); need for additional surgery; recurrence of fibroids; perforation (hysteroscopic route); infection
	Rare:	haemorrhage
Hysterectomy	Common:	infection
	Less common:	intra-operative haemorrhage; damage to other abdominal organs, such as the urinary tract or bowel; urinary dysfunction – frequent passing of urine and incontinence
	Rare:	thrombosis (DVT and clot on the lung)
	Very rare:	death
	(Complications are more likely when hysterectomy is performed in the presence of fibroids)	
Oophorectomy at the time of hysterectomy	Common:	menopausal-like symptoms

Choice

Choice for Women with HMB

D(GPP) - A woman with HMB should be given the opportunity to review and agree any treatment decision. She should have adequate time and support from healthcare professionals in the decision-making process.

D(GPP) - A woman with HMB and/or her doctor should have the option of gaining a second medical opinion where agreement on treatment options for HMB is not reached.

Pharmaceutical Treatments for HMB

D(GPP) - Pharmaceutical treatment should be considered where no structural or histological abnormality is present, or for fibroids less than 3 cm in diameter which are causing no distortion of the uterine cavity.

D(GPP) - The healthcare professional should determine whether hormonal contraception is acceptable to the woman before recommending treatment (for example, she may wish to conceive).

If history and investigations indicate that pharmaceutical treatment is appropriate and either hormonal or non-hormonal treatments are acceptable, treatments should be considered in the following order:*

1. Levonorgestrel-releasing intrauterine system (LNG-IUS) provided long-term (at least 12 months) use is anticipated **,+ **[A]**
2. Tranexamic acid **[A]** or nonsteroidal anti-inflammatory drugs (NSAIDs) **[A]** or combined oral contraceptives (COCs) **[B]**
3. Norethisterone (15 mg) daily from days 5 to 26 of the menstrual cycle, or injected long-acting progestogens.**,^ **[A]**

D(GPP) - If hormonal treatments are not acceptable to the woman, then either tranexamic acid or NSAIDs can be used.

D(GPP) - Women offered an LNGIUS should be advised of anticipated changes in the bleeding pattern, particularly in the first few cycles and maybe lasting longer than 6 months. They should therefore be advised to persevere for at least 6 cycles to see the benefits of the treatment.+

D(GPP) - If pharmaceutical treatment is required while investigations and definitive treatment are being organised, either tranexamic acid or NSAIDs should be used.

D(GPP) - When HMB coexists with dysmenorrhoea, NSAIDs should be preferred to tranexamic acid.

D(GPP) - Ongoing use of NSAIDs and/or tranexamic acid is recommended for as long as they are found to be beneficial by the woman.

D(GPP) - Use of NSAIDs and/or tranexamic acid should be stopped if it does not improve symptoms within three menstrual cycles.

D - When a first pharmaceutical treatment has proved ineffective, a second pharmaceutical treatment can be considered rather than immediate referral to surgery.

B - Use of a gonadotrophin-releasing hormone analogue could be considered prior to surgery or when all other treatment options for uterine fibroids, including surgery or uterine artery embolization (UAE), are contraindicated. If this treatment to be used for more than 6 months or if adverse effects are experienced then hormone replacement therapy (HRT) "addback" therapy is recommended.**

A - Danazol should not be routinely used for the treatment of HMB.

A - Oral progestogens given during the luteal phase only should not be used for the treatment of HMB.

A - Etamsylate should not be used for the treatment of HMB.

* World Health Organization "Pharmaceutical eligibility criteria for contraceptive use" (WHOMEC) apply. These criteria can be used to assess the individual's suitability for particular contraceptives. This allows informed decision making by the woman prior to the start of treatment. [http://www.ffprhc.org.uk/admin/uploads/298_UKMEC_200506.pdf]

** Check the Summary of Product Characteristics for current licensed indications. Informed consent is needed when using outside the licensed indications. This should be discussed and documented in the notes.

+ See "Long-acting reversible contraception," NICE clinical guideline 30, http://guidance.nice.org.uk/CG30, for more detail. (National Guideline Clearinghouse summary of the NICE guideline Long-acting reversible contraception: the effective and appropriate use of long-acting reversible contraception.)

^ In adolescents and women older than 40 years, refer to Committee on Safety of Medicines (CSM) advice issued in November 2004. Go to www.mhra.gov.uk and search for Depo-Provera.

Surgery as First-Line Treatment for HMB

Surgery as First-Line Treatment for HMB in Secondary Care

A - Endometrial ablation may be offered as an initial treatment for HMB after full discussion with the woman of the risks and benefits and of other treatment options.

D(GPP) - Hysterectomy should not be used as a first-line treatment solely for HMB.

Non-Hysterectomy Surgery for HMB

Endometrial Ablation/Resection

C - Endometrial ablation should be considered where bleeding is having a severe impact on a woman's quality of life, and she does not want to conceive in the future.

A - Endometrial ablation may be offered as an initial treatment for HMB after full discussion with the woman of the risks and benefits and of other treatment options.

D(GPP) - Women must be advised to avoid subsequent pregnancy and on the need to use effective contraception, if required, after endometrial ablation.

A - Endometrial ablation should be considered in women who have a normal uterus and also those with small uterine fibroids (less than 3 cm in diameter).

A - In women with HMB alone, with uterus no bigger than a 10 week pregnancy, endometrial ablation should be considered preferable to hysterectomy.

D(GPP) - All women considering endometrial ablation should have access to a second-generation ablation technique.

A - Second-generation ablation techniques should be used where no structural or histological abnormality is present. The second-generation techniques recommended for consideration are as follows. Providers should ensure that when purchasing any of these they buy the least expensive available option:* ** # +

- Impedance-controlled bipolar radiofrequency ablation (formerly NICE interventional procedure guidance 104)
- Fluid-filled thermal balloon endometrial ablation (TBEA) (formerly NICE interventional procedure guidance 6)
- Microwave endometrial ablation (MEA) (formerly NICE interventional procedure guidance 7)
- Free fluid thermal endometrial ablation (formerly NICE interventional procedure guidance 51)

D(GPP) - In TBEA, endometrial thinning is not needed.

A - In MEA, scheduling of surgery for postmenstrual phase is an alternative to endometrial thinning.

D(GPP) - First-generation ablation techniques (for example, rollerball endometrial ablation [REA] and transcervical resection of the endometrium [TCRE]) are appropriate if hysteroscopic myomectomy is to be included in the procedure.

* NICE have produced "Fluid-filled thermal balloon and microwave endometrial techniques for heavy menstrual bleeding. NICE technology appraisal guidance 78" on TBEA and MEA.

** This clinical guideline supersedes the following NICE interventional procedure guidances: "Balloon thermal endometrial ablation. IPG 6," "Microwave endometrial ablation. IPG 7," "Free fluid endometrial ablation. IPG 51" and "Impedance-controlled bipolar radiofrequency ablation for menorrhagia. IPG 104." However, "Endometrial cryotherapy for menorrhagia. NICE interventional procedure guidance 157" is not covered by this guideline.

Reference should be made to the limits on uterus size given by the manufacturer of the endometrial ablation device.

+ It is recommended that the Medicines and Healthcare products Regulatory Agency (MHRA) safety notices on endometrial ablation should be followed (MDA [1998] SN 9812 "Devices used for endometrial ablation achieved by thermal means," and MDA [1999] SN 1999(18) "Devices used for endometrial ablation").

Dilatation and Curettage

C - Dilatation and curettage should not be used as a therapeutic treatment.

Further Interventions for Uterine Fibroids Associated with HMB

D(GPP) - For women with large fibroids and HMB, and other significant symptoms such as dysmenorrhoea or pressure symptoms, referral for consideration of surgery or uterine artery embolisation (UAE) as first-line treatment can be recommended.

(See "Uterine artery embolisation for the treatment of fibroids," NICE interventional procedure guidance 94, http://guidance.nice.org.uk/IPG94.)

C - UAE, myomectomy or hysterectomy should be considered in cases of HMB where large fibroids (greater than 3 cm in diameter) are present and bleeding is having a severe impact on a woman's quality of life.

D(GPP) - When surgery for fibroid-related HMB is felt necessary then UAE, myomectomy and hysterectomy must all be considered, discussed and documented.

C - Women should be informed that UAE or myomectomy will potentially allow them to retain their fertility.

D - Myomectomy is recommended for women with HMB associated with uterine fibroids and who want to retain their uterus.

B - UAE is recommended for women with HMB associated with uterine fibroids and who want to retain their uterus and/or avoid surgery.

(See "Uterine artery embolisation for the treatment of fibroids," NICE interventional procedure guidance 94, http://guidance.nice.org.uk/IPG94.)

D(GPP) - Prior to scheduling of UAE or myomectomy, the uterus and fibroid(s) should be assessed by ultrasound. If further information about fibroid position, size, number and vascularity is required, MRI should be considered.

A - Pretreatment before hysterectomy and myomectomy with a gonadotrophin-releasing hormone analogue for 3 to 4 months should be considered where uterine fibroids are causing an enlarged or distorted uterus.

(Check the Summary of Product Characteristics for current licensed indications. Informed consent is needed when using outside the licensed indications. This should be discussed and documented in the notes.)

D(GPP) - If a woman is being treated with gonadotrophin-releasing hormone analogue and UAE is then planned, the gonadotrophin-releasing hormone analogue should be stopped as soon as UAE has been scheduled.

Hysterectomy

C - Hysterectomy should not be used as a first-line treatment solely for HMB. Hysterectomy should be considered only when:

- Other treatment options have failed, are contraindicated or are declined by the woman
- There is a wish for amenorrhoea
- The woman (who has been fully informed) requests it
- The woman no longer wishes to retain her uterus and fertility

D(GPP) - Women offered hysterectomy should have a full discussion of the implication of the surgery before a decision is made. The discussion should include: sexual feelings, fertility impact, bladder function, need for further treatment, treatment complications, the woman's expectations, alternative surgery and psychological impact.

C - Women offered hysterectomy should be informed about the increased risk of serious complications (such as intraoperative haemorrhage or damage to other abdominal organs) associated with hysterectomy when uterine fibroids are present.

D(GPP) - Women should be informed about the risk of possible loss of ovarian function and its consequences, even if their ovaries are retained during hysterectomy.

D(GPP) - Individual assessment is essential when deciding route of hysterectomy. The following factors need to be taken into account:

- Presence of other gynaecological conditions or disease
- Uterine size
- Presence and size of uterine fibroids
- Mobility and descent of the uterus
- Size and shape of the vagina
- History of previous surgery

A - Taking into account the need for individual assessment, the route of hysterectomy should be considered in the following order: first line vaginal; second line abdominal.

D(GPP) - Under circumstances such as morbid obesity or the need for oophorectomy during vaginal hysterectomy, the laparoscopic approach should be considered, and appropriate expertise sought.

D(GPP) - When abdominal hysterectomy is decided upon then both the total method (removal of the uterus and the cervix) and subtotal method (removal of the uterus and preservation of the cervix) should be discussed with the woman.

Removal of Ovaries at the Time of Hysterectomy

Oophorectomy

D(GPP) - Removal of healthy ovaries at the time of hysterectomy should not be undertaken.

D(GPP) - Removal of ovaries should only be undertaken with the express wish and consent of the woman.

D(GPP) - Women with a significant family history of breast or ovarian cancer should be referred for genetic counselling prior to a decision about oophorectomy.

(See "The classification and care of women at risk of familial breast cancer in primary, secondary and tertiary care," NICE clinical guideline 41, http://guidance.nice.org.uk/CG41, for more detail.)

D(GPP) - In women under 45 considering hysterectomy for HMB with other symptoms that may be related to ovarian dysfunction (for example, premenstrual syndrome), a trial of pharmaceutical ovarian suppression for at least 3 months should be used as a guide to the need for oophorectomy.

D(GPP) - If removal of ovaries is being considered, the impact of this on the woman's well-being and, for example, the possible need for hormone replacement therapy (HRT) should be discussed.

D(GPP) - Women considering bilateral oophorectomy should be informed about the impact of this treatment on the risk of ovarian and breast cancer.

Competencies

Competencies

Training

D(GPP) - All those involved in undertaking surgical or radiological procedures to diagnose and treat HMB should demonstrate competence (including both technical and consultation skills) either during their training or in their subsequent practice.

D(GPP) - The operative competence of healthcare professionals who are acquiring new skills in procedures to diagnose and treat HMB should be formally assessed by trainers through a structured process such as that defined within training schemes of the Post-graduate Medical Education and Training Board (PMETB), the Royal Colleges and/or the Society and College of Radiographers (SCoR).

D(GPP) - Training programmes must be long enough to enable healthcare professionals to achieve competency in complex procedures when these are appropriate (for example, operations for fibroids that are large or in an awkward position, or using laparoscopic techniques). These training programmes will usually be located in units with a particular interest and sufficient workload to allow experience of these procedures.

Maintenance

D(GPP) - Maintenance of surgical, imaging or radiological skills requires a robust clinical governance framework including audit of numbers, decision making, case-mix issues and outcomes of all treatments at both individual operator and organisational levels. These data should be used to demonstrate good clinical practice.

D(GPP) - Established healthcare professionals should be able to demonstrate that their training, experience and current practice meets or exceeds the standards laid out for newly trained professionals.

Governance

D(GPP) - If a healthcare professional lacks competence to undertake a procedure then they should refer the woman to a professional with the appropriate skill. Organisations that commission services should be responsible (through service specification based on robust audit data) for identifying and contracting professionals with appropriate skills.

Definitions:

Levels of Evidence for Intervention Studies

Level	Source of Evidence
1++	High-quality meta-analyses, systematic reviews of randomised controlled trials (RCTs) or RCTs with a very low risk of bias
1+	Well-conducted meta-analyses, systematic reviews of RCTs or RCTs with a low risk of bias
1−	Meta-analyses, systematic reviews of RCTs or RCTs with a high risk of bias
2++	High-quality systematic reviews of case–control or cohort studies; high-quality case–control or cohort studies with a very low risk of confounding bias or chance and a high probability that the relationship is causal
2+	Well-conducted case–control or cohort studies with a low risk of confounding bias or chance and a moderate probability that the relationship is causal
2−	Case–control or cohort studies with a high risk of confounding bias or chance and a significant risk that the relationship is not causal
3	Non-analytical studies (for example, case reports, case series)
4	Expert opinion, formal consensus

Levels of Evidence for Studies of the Accuracy of Diagnostics Tests

Level	Type of Evidence
Ia	Systematic reviews (with homogeneity)[a] of level-1 studies[b]
Ib	Level-1 studies[b]
II	Level-2 studies[c]; systematic reviews of level-2 studies
III	Level-3 studies[d]; systematic reviews of level-3 studies
IV	Consensus, expert committee reports or opinions and/or clinical experience without explicit critical appraisal; or based on physiology, bench research or 'first principles'

[a] Homogeneity means there are no or only minor variations in the directions and degrees of results between individual studies that are included in the systematic review.

[b] Level-1 studies are studies that use a blind comparison of the test with a validated reference standard (gold standard) in a sample of patients that reflects the population to whom the test would apply.

[c] Level-2 studies are studies that have only one of the following:

- Narrow population (the sample does not reflect the population to whom the test would apply)
- Use a poor reference standard (defined as that where the 'test' is included in the 'reference', or where the 'testing' affects the 'reference')
- The comparison between the test and reference standard is not blind
- Case–control studies

[d] Level-3 studies are studies that have at least two or three of the features listed above.

Classification of Recommendations

Class	Evidence
A	• At least one meta-analysis, systematic review, or randomised controlled trial (RCT) that is rated as 1++, and is directly applicable to the target population, or • A systematic review of RCTs or a body of evidence that consists principally of studies rated as 1+, is directly applicable to the target population and demonstrates overall consistency of results, or • Evidence drawn from a National Institute for Health and Clinical Excellence (NICE) technology appraisal.
B	• A body of evidence that includes studies rated as 2++, is directly applicable to the target population and demonstrates overall consistency of results, or • Extrapolated evidence from studies rated as 1++ or 1+.
C	• A body of evidence that includes studies rated as 2+, is directly applicable to the target population and demonstrates overall consistency of results, or • Extrapolated evidence from studies rated as 2++.
D	• Evidence level 3 or 4, or • Extrapolated evidence from studies rated as 2+, or • Formal consensus.
D(GPP)	• A good practice point (GPP) is a recommendation for best practice based on the experience of the Guideline Development Group.

CLINICAL ALGORITHM(S)

A clinical algorithm titled, "Care Pathway for Heavy Menstrual Bleeding," is included in the original guideline document.

EVIDENCE SUPPORTING THE RECOMMENDATIONS

TYPE OF EVIDENCE SUPPORTING THE RECOMMENDATIONS

The type of supporting evidence is identified and graded for each recommendation (see "Major Recommendations").

BENEFITS/HARMS OF IMPLEMENTING THE GUIDELINE RECOMMENDATIONS

POTENTIAL BENEFITS

Appropriate management of patients with heavy menstrual bleeding

POTENTIAL HARMS

Refer to the table in the "Major Recommendations" field concerning unwanted outcomes of interventions for heavy menstrual bleeding.

CONTRAINDICATIONS

CONTRAINDICATIONS

- Use of a gonadotrophin-releasing hormone analogue (GnRH-a) is contraindicated when undertaking uterine artery embolization (UAE) owing to the effect that it has on blood vessels that makes the procedure more difficult.
- Large uterus size, presence of pathology and low uterine mobility are all contraindications to the vaginal route being used for hysterectomy.

QUALIFYING STATEMENTS

QUALIFYING STATEMENTS

- The use of registered names, trademarks, etc. in this publication does not imply, even in the absence of a specific statement, that such names are exempt from the relevant laws and regulations and therefore for general use.
- While every effort has been made to ensure the accuracy of the information contained within this publication, the publisher can give no guarantee for information about drug dosage and application thereof contained in this guideline. In every individual case the respective user must check current indications and accuracy by consulting other pharmaceutical literature and following the guidelines laid down by the manufacturers of specific products and the relevant authorities in the country in which they are practising.
- Advice on treatment options is based on the best evidence available to the Guideline Development Group. When referring to pharmacological interventions, the guideline normally recommends use within the licensed indications. Exceptionally, and only where the evidence clearly supports it, the guideline may recommend use of a pharmacological intervention beyond its licensed indications. The guideline recommendations assume that prescribers will use the Summary of Product Characteristics for prescribing decisions for individual women. The recommendations are based on the assessment of short- and long-term outcomes and complications for all treatments.
- Clinical guidelines have been defined as systematically developed statements which assist clinicians and patients in making decisions about appropriate treatment for specific conditions. This guideline has been developed with the aim of providing guidance on heavy menstrual bleeding (HMB). The effectiveness of the various treatments as well as their risks and benefits are discussed in relation to their use in the treatment of HMB but the discussion cannot be extrapolated to the use of particular treatments to relieve other symptoms, such as hysterectomy for cancer or endometriosis. The implications of each treatment in relation to fertility are also clearly stated so

that no woman will undergo treatment that renders her infertile unless this is her specific wish.

IMPLEMENTATION OF THE GUIDELINE

DESCRIPTION OF IMPLEMENTATION STRATEGY

The Healthcare Commission assesses the performance of National Health Service (NHS) organisations in meeting core and developmental standards set by the Department of Health in 'Standards for better health', issued in July 2004. Implementation of clinical guidelines forms part of the developmental standard D2. Core standard C5 says that national agreed guidance should be taken into account when NHS organisations are planning and delivering care.

The National Institute for Health and Clinical Excellence (NICE) has developed tools to help organisations implement this guidance (listed below). These are available on their Website (http://guidance.nice.org.uk/CG44).

- Slides highlighting key messages for local discussion
- Costing tools
    - Costing report to estimate the national savings and costs associated with implementation
    - Costing template to estimate the local costs and savings involved
- Implementation advice on how to put the guidance into practice and national initiatives which support this locally
- Audit criteria to monitor local practice

A generic guide to implementation called "How to put NICE guidance into practice" is also available on the NICE Web site.

Key Priorities for Implementation

Impact of Heavy Menstrual Bleeding (HMB) on Women

- For clinical purposes, HMB should be defined as excessive menstrual blood loss which interferes with the woman's physical, emotional, social and material quality of life, and which can occur alone or in combination with other symptoms. Any interventions should aim to improve quality of life measures.]

History Taking, Examination and Investigations for HMB

- If appropriate, a biopsy should be taken to exclude endometrial cancer or atypical hyperplasia. Indications for a biopsy include, for example, persistent intermenstrual bleeding, and in women aged 45 and over treatment failure or ineffective treatment.
- Ultrasound is the first-line diagnostic tool for identifying structural abnormalities.

Education and Information Provision

- A woman with HMB referred to specialist care should be given information before her outpatient appointment. The Institute's information for patients ('Understanding NICE guidance') is available from http://guidance.nice.org.uk/CG44/PublicInfo/pdf/English.

Pharmaceutical Treatments for HMB

- If history and investigations indicate that pharmaceutical treatment is appropriate and either hormonal or non-hormonal treatments are acceptable, treatments should be considered in the following order:
    1. Levonorgestrel-releasing intrauterine system (LNG-IUS) provided long-term (at least 12 months) use is anticipated

       (Check the Summary of Product Characteristics for current licensed indications. Informed consent is needed when using outside the licensed indications. This should be discussed and documented in the notes. See Long-acting reversible contraception, NICE clinical guideline 30 for more detail)

    2. Tranexamic acid or nonsteroidal anti-inflammatory drugs (NSAIDs) or combined oral contraceptives (COCs)
    3. Norethisterone (15 mg) daily from days 5 to 26 of the menstrual cycle, or injected long-acting progestogens

- If hormonal treatments are not acceptable to the woman, then either tranexamic acid or NSAIDs can be used.

Non-Hysterectomy Surgery for HMB

- In women with HMB alone, with uterus no bigger than a 10 week pregnancy, endometrial ablation should be considered preferable to hysterectomy.

Hysterectomy

- Taking into account the need for individual assessment, the route of hysterectomy should be considered in the following order: first line vaginal; second line abdominal.

Competencies

- Maintenance of surgical, imaging or radiological skills requires a robust clinical governance framework including audit of numbers, decision making, case-mix issues and outcomes of all treatments at both individual operator and organisational levels. These data should be used to demonstrate good clinical practice.

IMPLEMENTATION TOOLS

Audit Criteria/Indicators
Clinical Algorithm
Patient Resources
Quick Reference Guides/Physician Guides

Resources
Slide Presentation

For information about availability, see the "Availability of Companion Documents" and "Patient Resources" fields below.

INSTITUTE OF MEDICINE (IOM) NATIONAL HEALTHCARE QUALITY REPORT CATEGORIES

IOM CARE NEED

Getting Better
Living with Illness

IOM DOMAIN

Effectiveness
Patient-centeredness

IDENTIFYING INFORMATION AND AVAILABILITY

BIBLIOGRAPHIC SOURCE(S)

National Collaborating Centre for Women's and Children's Health. Heavy menstrual bleeding. London (UK): Royal College of Obstetricians and Gynaecologists (RCOG); 2007 Jan. 164 p. [606 references]

ADAPTATION

Not applicable: The guideline was not adapted from another source.

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GUIDELINE DEVELOPER(S)

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SOURCE(S) OF FUNDING

National Institute for Health and Clinical Excellence (NICE)

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Guideline Development Group

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FINANCIAL DISCLOSURES/CONFLICTS OF INTEREST

AnnaMarie Belli: conference funding from Boston Scientific, funding to department for research fellow from Johnson & Johnson.

Dianne Crowe: no interests declared.

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GUIDELINE STATUS

This is the current release of the guideline.

Clinical guidelines commissioned by National Institute for Health and Clinical Excellence (NICE) are published with a review date 4 years from date of

publication. Reviewing may begin earlier than 4 years if significant evidence that affects guideline recommendations is identified sooner. The updated guideline will be available within 2 years of the start of the review process.

GUIDELINE AVAILABILITY

Electronic copies: Available in Portable Document Format (PDF) format from the National Institute for Health and Clinical Excellence (NICE) Web site.

AVAILABILITY OF COMPANION DOCUMENTS

The following are available:

- Heavy menstrual bleeding. NICE guideline. London (UK): National Institute for Health and Clinical Excellence; 2007 Jan. 30 p. (Clinical guideline; no. 44). Electronic copies: Available in Portable Document Format (PDF) and MS Word format from the National Institute for Health and Clinical Excellence (NICE) Web site.
- Heavy menstrual bleeding. Quick reference guide. London (UK): National Institute for Health and Clinical Excellence; 2007 Jan. 11 p. (Clinical guideline; no. 44). Electronic copies: Available in Portable Document Format (PDF) from the NICE Web site.
- Heavy menstrual bleeding. Evidence tables. RCOG Press. Royal College of Obstetricians and Gynaecologists; 2007 Jan. 250 p. Electronic copies: Available in Portable Document Format (PDF) from the NICE Web site.
- Heavy menstrual bleeding. Costing template. London (UK): National Institute for Health and Clinical Excellence; 2007 Jan. Various p. (Clinical guideline; no. 44). Electronic copies: Available in Portable Document Format (PDF) from the NICE Web site.
- Heavy menstrual bleeding. Costing report. London (UK): National Institute for Health and Clinical Excellence; 2007 Jan. 43 p. (Clinical guideline; no. 44). Electronic copies: Available in Portable Document Format (PDF) from the NICE Web site.
- Heavy menstrual bleeding. Implementation advice. London (UK): National Institute for Health and Clinical Excellence; 2007 Jan. 16 p. (Clinical guideline; no. 44). Electronic copies: Available in Portable Document Format (PDF) from the NICE Web site.
- Heavy menstrual bleeding. Presenter slides. London (UK): National Institute for Health and Clinical Excellence; 2007 Jan. 23 p. (Clinical guideline; no. 44). Electronic copies: Available in Portable Document Format (PDF) from the NICE Web site.
- Heavy menstrual bleeding. Audit criteria. London (UK): National Institute for Health and Clinical Excellence; 2007 Jan. 14 p. (Clinical guideline; no. 44). Electronic copies: Available in Portable Document Format (PDF) from the NICE Web site.

Print copies: Available from the National Health Service (NHS) Response Line 0870 1555 455. ref: N1180. 11 Strand, London, WC2N 5HR.

PATIENT RESOURCES

The following is available:

- Treatment and care for women with heavy periods. Understanding NICE guidance. Information for people who use NHS services. London (UK): National Institute for Health and Clinical Excellence; 2007 Jan. 6 p. (Clinical guideline; no. 44). Electronic copies: Available in Portable Document Format (PDF) and MS Word format from the National Institute for Health and Clinical Excellence (NICE) Web site.

Print copies: Available from the National Health Service (NHS) Response Line 0870 1555 455. ref: N1181. 11 Strand, London, WC2N 5HR.

Please note: This patient information is intended to provide health professionals with information to share with their patients to help them better understand their health and their diagnosed disorders. By providing access to this patient information, it is not the intention of NGC to provide specific medical advice for particular patients. Rather we urge patients and their representatives to review this material and then to consult with a licensed health professional for evaluation of treatment options suitable for them as well as for diagnosis and answers to their personal medical questions. This patient information has been derived and prepared from a guideline for health care professionals included on NGC by the authors or publishers of that original guideline. The patient information is not reviewed by NGC to establish whether or not it accurately reflects the original guideline's content.

NGC STATUS

This summary was completed by ECRI Institute on March 15, 2007.

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